Medicare Coverage of Durable Medical Equipment

This official government booklet explains…

- What durable medical equipment is
- Which durable medical equipment is covered in the Original Medicare Plan
- Where to get help with your questions

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Do you need durable medical equipment? Medicare can help.

This booklet explains Medicare coverage for durable medical equipment in the Original Medicare Plan (sometimes called fee-for-service) and what you might need to pay. Durable medical equipment includes things like

- home oxygen equipment,
- hospital beds,
- walkers, and
- wheelchairs.

It's important for you to know that Medicare covers durable medical equipment and what you may need to pay. Talk to your doctor if you think you need some type of durable medical equipment to improve your health.

If you have questions about durable medical equipment costs or coverage after reading this booklet, you can

- call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- call the Durable Medical Equipment Regional Carrier in your state (see page 11).

Words in blue are defined on pages 12–13.

Note: The information in this booklet was correct when it was printed. Changes may occur after printing. For the most up-to-date information, look at www.medicare.gov on the web. Select "Your Medicare Coverage." Or, call 1-800-MEDICARE (1-800-633-4227). A Customer Service Representative can tell you if the information has been updated. TTY users should call 1-877-486-2048.

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Note: At the time of printing, the Durable Medical Equipment Regional Carrier telephone numbers listed on page 11 were correct. To get the most up-to-date telephone numbers, look at www.medicare.gov on the web. Select "Helpful Contacts." For additional information, call 1-800-MEDICARE (1-800-633-4227). This 24-hour Helpline is available to help you with your Medicare questions. TTY users should call 1-877-486-2048.

Medicare Coverage of Durable Medical Equipment isn't a legal document. The official Medicare program provisions are contained in the relevant laws, regulations, and rulings.

What is durable medical equipment?

Durable medical equipment is medical equipment that is prescribed by a doctor (or, if Medicare allows, a nurse practitioner, physician assistant, or clinical nurse specialist can order the equipment) for use in the home. These items must be durable and primarily for medical purposes, such as walkers, wheelchairs, or hospital beds. This type of equipment is for someone who is sick or injured.

Who can get durable medical equipment?

Anyone who has Medicare Part B under the Original Medicare Plan can get durable medical equipment as long as the equipment is medically necessary.

Does the Original Medicare Plan cover durable medical equipment?

Under Medicare Part B, the Original Medicare Plan covers durable medical equipment that your doctor prescribes for use in your home. Medicare may require your doctor (or a nurse practitioner, physician assistant, or clinical nurse specialist) to examine you in-person before you can get durable medical equipment. A hospital or nursing home that mostly provides skilled care can't qualify as your "home" in this situation.

Note: If you are in a skilled nursing facility and the facility provides you with durable medical equipment, the facility is responsible for this equipment.

What if I need durable medical equipment and I am in a Medicare + Choice Plan?

If you are in a Medicare + Choice Plan (pronounced "Medicare plus Choice") and you need durable medical equipment, call your plan to find out if the equipment is covered and how much you will have to pay. If your plan leaves the Medicare program and you are using medical equipment such as oxygen or a wheelchair, call the telephone number on your Medicare + Choice Plan card. Ask for Utilization Management. They will tell you how you can get care under the Original Medicare Plan or under a new Medicare + Choice Plan.

Words in blue are defined on pages 12–13.

What if I need durable medical equipment and I am in a Medicare + Choice Plan? (continued)

If you are getting home care or using medical equipment and you choose to join a new Medicare + Choice Plan, you should call the new plan as soon as possible and ask for Utilization Management. They can tell if your equipment is covered and how much it will cost. If you return to the Original Medicare Plan, you should tell your supplier to bill Medicare directly after the date your coverage in the Medicare + Choice Plan ends.

How do I get the durable medical equipment I need?

To get the durable medical equipment you need

- see your doctor, and
- go to a supplier enrolled in Medicare.

If you need durable medical equipment, your doctor (or, if Medicare allows, a nurse practitioner, physician assistant, or clinical nurse specialist) must prescribe the type of equipment you need for use in your home. For some equipment, Medicare also requires your doctor or one of the doctor's office staff to fill out a special form and send it to Medicare to get approval for the equipment. This is called a Certificate of Medical Necessity. Your supplier will work with your doctor to see that all required information is submitted to Medicare. If your prescription and/or condition changes, your doctor must complete and submit a new, updated certificate.

The following durable medical equipment items require a Certificate of Medical Necessity:

- Air-fluidized beds
- Bone growth (or osteogenesis) stimulators
- External infusion pumps
- Hospital beds
- Lymphedema pumps/pneumatic compression devices
- Oxygen
- Power Operated Vehicles (POVs) or scooters (see page 5)
- Seat lift mechanisms
- Transcutaneous electronic nerve stimulators (TENS)
- Wheelchairs

Words in blue are defined on pages 12–13.

How do I get the durable medical equipment I need? (continued)

You should go to a participating supplier or an enrolled supplier to get your durable medical equipment. **You must go to a supplier enrolled in the Medicare program for Medicare to cover the equipment.** To find a supplier that is enrolled in the Medicare program, look at www.medicare.gov on the web. Select "Supplier Directory." You can also call 1-800-MEDICARE (1-800-633-4227) to get this information. TTY users should call 1-877-486-2048.

A supplier enrolled in the Medicare program will have a Medicare supplier number. Suppliers have to meet strict standards to qualify for a Medicare supplier number. If your supplier **doesn't** have a supplier number, Medicare won't pay your claim, even if your supplier is a large chain or department store that sells more than just durable medical equipment.

Special note about power wheelchairs and scooters

For Medicare to cover a power wheelchair or scooter, your doctor must state that you need it because of your medical condition. Medicare won't cover a power wheelchair or scooter only for your convenience or for leisure activities. Most suppliers who work with Medicare are honest. There are a few who aren't honest. Medicare is working very hard with other government agencies to protect you and the Medicare program from dishonest suppliers of power wheelchairs and scooters.

For more information about Medicare's coverage of power wheelchairs or scooters, get a free copy of *Protecting Medicare's Power Wheelchair and Scooter Benefit* (CMS Pub. No. 11046) at www.medicare.gov on the web. Select "Publications." Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

What is covered and how much does it cost?

The chart below and on page 7 shows what items Medicare covers and how much you have to pay for these items. This list doesn't include all covered durable medical equipment. The chart on page 7 lists the prosthetic and orthotic items that Medicare covers. If you have a Medigap policy, it may help cover some of the costs listed below and on page 7.

Durable Medical Equipment	
What Medicare Covers	**What You Pay**
• Air fluidized beds* • Blood glucose monitors • Bone growth (or osteogenesis) stimulators* • Canes (except white canes for the blind) • Commode chairs • Crutches • Home oxygen equipment and supplies* • Hospital beds* • Infusion pumps and some medicines used in them (if reasonable and necessary)* • Lymphedema pumps/pneumatic compression devices* • Nebulizers and some medicines used in them (if reasonable and necessary) • Patient lifts* • Power Operated Vehicles (POVs) or scooters* • Suction pumps • Traction equipment • Transcutaneous electronic nerve stimulators (TENS)* • Ventilators or respiratory assist devices • Walkers • Wheelchairs*	Generally, you pay 20 percent of the Medicare-approved amount after you pay your $100 Medicare Part B deductible for the year. Medicare pays the other 80 percent. The Medicare-approved amount is the lower of the actual charge for the item or the fee Medicare sets for the item. However, the amount you pay may vary because Medicare pays for different kinds of durable medical equipment in different ways. You may be able to rent or buy the equipment. Your Durable Medical Equipment Regional Carrier (DMERC) can give you more specific information (see page 11).

* You must get a Certificate of Medical Necessity before you can get this equipment (see page 4).

Prosthetic and Orthotic Items	
What Medicare Covers	**What You Pay**
• Arm, leg, back, and neck braces • Artificial limbs and eyes • Breast prostheses (including a surgical brassiere) after a mastectomy. • Ostomy supplies for people who have had a colostomy, ileostomy, or urinary ostomy. Medicare covers the amount of supplies your doctor says you need based on your condition. • Prosthetic devices needed to replace an internal body part or function. • Therapeutic shoes or inserts for people with diabetes who have severe diabetic foot disease. The doctor who treats your diabetes must certify your need for therapeutic shoes or inserts. A podiatrist or other qualified doctor must prescribe the shoes and inserts. A doctor or other qualified individual like a pedorthist, orthotist, or prosthetist must fit and provide the shoes. Medicare helps pay for one pair of therapeutic shoes and inserts per calendar year. Shoe modifications may be substituted for inserts.	You pay 20 percent of the Medicare-approved amount after you pay your $100 Medicare Part B deductible for the year. Medicare pays the other 80 percent. These amounts may be different if the supplier doesn't accept assignment (see page 8).
• Cataract glasses, contact lenses, or intraocular lenses after cataract surgery with an intraocular lens An ophthalmologist or an optometrist authorized to provide these services in your state may provide these items. **Important:** Only standard frames are covered. Eyeglasses and cataract lenses are covered even if you had the surgery before you had Medicare. Payment may be made for lenses for both eyes even if cataract surgery involved only one eye.	You are covered for one pair of eyeglasses or contact lenses after each cataract surgery with an intraocular lens. You pay 20 percent of the Medicare-approved amount after you pay the $100 Medicare Part B deductible for the year. Medicare pays the other 80 percent. Costs may be different if the supplier doesn't accept assignment (see page 8). If you want to upgrade the frames, you pay any additional cost.

What is "Assignment" in the Original Medicare Plan and why is it important?

Assignment is an agreement between Medicare and doctors, other health care providers, and suppliers of health care equipment and supplies (like wheelchairs, oxygen, braces, and ostomy supplies). Doctors, providers, and suppliers who agree to accept assignment accept the Medicare-approved amount as full payment. You pay the coinsurance (usually 20 percent of the approved amount) and deductible amounts.

If the supplier accepts assignment, you pay 20 percent of the Medicare-approved amount after you pay your $100 Medicare Part B deductible for the year. Medicare pays the other 80 percent. Suppliers who agree to accept assignment on all durable medical equipment claims are called "participating suppliers."

If a durable medical equipment supplier doesn't accept assignment, **there is no limit to what they can charge.** You may have to pay the entire bill (your share and Medicare's share) at the time you get the durable medical equipment. The supplier will send the bill to Medicare. Then, Medicare will reimburse you for its share of the charge later.

Note: Ask if the supplier is a participating supplier in the Medicare program before you get durable medical equipment.
If the supplier is a participating supplier, they **must** accept assignment. If the supplier is enrolled in Medicare, but isn't "participating" they have the option to accept assignment. If the supplier isn't enrolled in Medicare, Medicare **won't** pay your claim.

How will I know if I can buy or rent durable medical equipment?

Words in blue are defined on pages 12–13.

If your supplier is a Medicare-enrolled supplier, they will know whether Medicare allows you to buy or rent durable medical equipment. Medicare pays for most durable medical equipment on a rental basis. Payment on a purchase basis is only allowed for inexpensive or routinely purchased items, such as canes, power wheelchairs, and, in rare cases, items that must be made specifically for you.

How will I know if I can buy or rent durable medical equipment? (continued)

Buying equipment

If you **buy** Medicare-covered durable medical equipment, Medicare may also cover repairs and replacement parts. Medicare will pay 80 percent of the Medicare-approved amount for purchase of the item. Medicare will also pay 80 percent of the Medicare-approved amount (up to the cost of replacing the item) for repairs. You pay the other 20 percent. Your costs may be higher if the supplier doesn't accept assignment.

Note: The equipment you buy may be replaced if it's lost, stolen, damaged beyond repair, or used for more than the reasonable useful lifetime of the equipment.

Renting equipment

If you **rent** durable medical equipment, Medicare makes monthly payments for use of the equipment, but the rules for how long monthly payments continue varies based on the type of equipment. Total rental payments for inexpensive or routinely purchased items are limited to the fee Medicare sets to purchase the item. If you will need these items for more than a few months, you may decide to purchase these items rather than rent them. Monthly payments for oxygen and oxygen equipment, and frequently serviced items, such as ventilators, are made as long as the equipment is medically necessary. The payment rules for rented equipment called "capped rental items" are provided below. Medicare will pay 80 percent of the Medicare-approved amount each month for use of the item. You pay the other 20 percent after you pay the $100 Medicare Part B deductible.

The supplier will pick up the equipment when you no longer need it. Any costs for repairs or replacement parts for the rented equipment are the supplier's responsibility. The supplier will also pick up the rented equipment if it needs repairs. You don't have to bring the rented equipment back to the supplier.

Words in blue are defined on pages 12–13.

Capped rental items

For certain kinds of durable medical equipment, like wheelchairs or hospital beds, Medicare requires the supplier to send you a "purchase option" letter in the 10th rental month (after you have rented an item for nine continuous months). You should respond to the purchase option letter within 30 days and indicate whether you would like to buy or continue renting the equipment.

If you choose the purchase option for a capped rental item

If you choose the purchase option for your capped rental item, 13 monthly rental payments must be made as follows:

1. You pay your $100 Medicare Part B deductible for the year,
2. Medicare pays 80 percent of each of the 13 monthly rental payments, and
3. You pay 20 percent of each of the 13 monthly rental payments.

After these 13 rental payments are made, **you own the equipment**. The amount you pay may be higher if the supplier doesn't accept assignment (see page 8).

Note: Any rental payments you made before getting the "purchase option" letter counts towards the 13 rental payments.

If you choose to continue renting a capped rental item

If you choose to continue to **rent** the equipment or don't respond to the purchase option letter, Medicare will pay 80 percent of 15 rental payments. You pay the other 20 percent after you pay the $100 Medicare Part B deductible.

After 15 monthly rental payments, you can use the equipment without being charged a rental fee. However, beginning six months after the 15th rental payment, your supplier may charge a maintenance and servicing fee which you may have to pay to the supplier twice a year (whether or not service is provided). Medicare pays 80 percent of this fee (up to the amount of the rental payment for the first month of the equipment's use). You pay the other 20 percent. If the supplier doesn't accept assignment, your costs may be higher. **Even though the supplier still owns the equipment, you can keep it as long as it's medically necessary.**

Note: If your doctor prescribes a capped rental item (like a nebulizer or manual wheelchair) and you decide to buy it without first renting for 13 months, Medicare won't pay for any portion of it. The only exception to this rule is power or motorized wheelchairs, which you can buy as soon as you start using the equipment. Medicare will pay 80 percent of the costs.

Words in blue are defined on pages 12–13.

For more information

Who can I call if I have questions about durable medical equipment?

If you have any questions about durable medical equipment, you can call the Durable Medical Equipment Regional Carrier (DMERC) in your state at the telephone numbers below:

This page has been intentionally left blank. It contains phone number information. For the most recent phone number information, please visit the Helpful Contacts section of our web site. Thank you.

Words to know

Assignment - In the Original Medicare Plan, this means a doctor, other health care provider, and supplier of health care equipment and supplies agree to accept Medicare's fee as full payment. If you are in the Original Medicare Plan, it can save you money if your doctor, provider, or supplier accepts assignment. You still pay your 20 percent share of the cost and Medicare pays 80 percent of the cost.

Capped rental item - Durable medical equipment (like nebulizers or manual wheelchairs) that

- costs more than $150, and
- the supplier rents it to people with Medicare more than 25 percent of the time.

Certificate of Medical Necessity - A form required by Medicare that allows you to use certain durable medical equipment prescribed by your doctor or one of the doctor's office staff.

Coinsurance - The percent of the Medicare-approved amount that you have to pay after you pay the deductible for Part A and/or Part B. In the Original Medicare Plan, the coinsurance payment is a percentage of the Medicare-approved amount for the service (like 20 percent for Part B services).

Deductible - The amount you must pay for health care before Medicare begins to pay, either each benefit period for Part A, or each year for Part B. These amounts can change every year.

Durable Medical Equipment - Medical equipment that is ordered by a doctor (or, if Medicare allows, a nurse practitioner, physician assistant, or clinical nurse specialist) for use in the home. A hospital or nursing home that mostly provides skilled care can't qualify as a "home" in this situation. These items must be reusable, such as walkers, wheelchairs, or hospital beds.

Durable Medical Equipment Regional Carrier (DMERC) - A private company that contracts with Medicare to pay bills for durable medical equipment.

Infusion Pumps - Pumps for giving fluid or medication into your vein at a specific rate or over a set amount of time.

Words to know

Medically Necessary - Services or supplies that

- are proper and needed for the diagnosis or treatment of your medical condition,
- are provided for the diagnosis, direct care, and treatment of your medical condition,
- meet the standards of good medical practice in the local area, and
- are not mainly for the convenience of you or your doctor.

Medicare-Approved Amount - The payment Medicare approves for a covered medical service. This is the amount a doctor or supplier is paid by you and Medicare for a service or supply for durable medical equipment, prosthetics, and orthotics. The Medicare-approved amount is equal to the lower of the actual charge or the fee Medicare sets for the item. The approved amount is sometimes called the "Approved Charge."

Medicare + Choice Plan - A Medicare program that gives you more choices among health plans. Everyone who has Medicare Parts A and B is eligible, except those who have End-Stage Renal Disease (unless certain exceptions apply).

Medigap Policy - A Medicare supplement insurance policy sold by private insurance companies to fill "gaps" in Original Medicare Plan coverage. Except in Massachusetts, Minnesota, and Wisconsin, there are ten standardized plans labeled Plan A through Plan J. Medigap policies only work with the Original Medicare Plan.

Nebulizers - Equipment to give medicine in a mist form to your lungs.

Original Medicare Plan - A pay-per-visit health plan that lets you go to any doctor, hospital, or other health care supplier who accepts Medicare and is accepting new Medicare patients. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance). The Original Medicare Plan has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).

Patient Lifts - Equipment to move a patient from a bed or wheelchair using your strength or a motor.

**U.S. DEPARTMENT OF
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Para obtener este folleto en español, llame gratis al 1-800-MEDICARE (1-800-633-4227). Los usuarios de TTY deben llamar al 1-877-486-2048.